



Editorial

Principles of patient-centered care in control of terminal symptoms

Age-friendly health care accentuates the need to provide terminally ill elderly patients with “safe and cost-effective services,” and symptom management remains a top priority in hospice palliative care.^{1,2} Whether the disease-oriented model that guides the assessments and treatment of the clinical symptoms of terminal patients is compatible with palliative care is an issue demanding grave concern.

Both single- and cross-disciplinary task groups have been established to assess constipation and to examine multidisciplinary collective clinical experience for chronic cough. However, it should be noted that the clinical manifestation of terminal cancer patients is predominately marked with a common pathway resulted from multi-organ system failure and encompassing an average of nine symptoms. Neither constipation nor chronic cough should be treated as an independent symptom impervious to the influence of other coexisting symptoms. Moreover, both constipation and chronic cough are unrelated to the primary tumor site.³ In terms of symptom assessment, the terminal and frail status should therefore be granted priority for consideration, and the application of any invasive diagnostic procedure needs to be carefully evaluated so as to avoid any potential damage it may cause. Pharmaceutical treatment should be guided by the principles of simplicity and safety, and any drugs that could aggravate the symptoms must be suspended when the disease proves incurable. Also to be noted is that opioid-based symptom control, assessment, and treatment should take into careful consideration of the relationship between morphine and the symptoms. Assessment of chronic cough in terminal patients, for example, should find its prerequisite in the inefficacy of morphine, and that of constipation should first rule out morphine as the cause of the symptom.

Symptom control and the physical–psychological adjustments in terminal patients are marked with a positive correlation.³ In observing the principle of patient-centered care, one should take note that any symptom may have its self-defense mechanism and an end point to medical treatment. Whether they would produce negative impacts—such as conscious disturbance or impaired self-control—that interfere the patient’s end-of-life preparation is an important issue requiring careful consideration.

The functional status and predicted survival time are two critical concerns in symptom treatment for terminal patients. Normal treatment based on the symptom of one single organ or system does not work with terminal diseases. For terminal patients, even the same stage in the dying process may require different strategies of symptom control. Upon entering the palliative ward, patients with an estimated survival time of 3 weeks may find their physical symptoms alleviated due to the care of the hospice team and the administration of drugs during the initial stage. In the middle stage, their physical symptoms experience steady deterioration as the

body organs and systems start to fail; psychological adjustments and social supports may help ease the symptom at this stage. By the end stage, however, patients are literally in the face of death where only spiritual enlightenment, not medical treatment, can help them manage the fear of dying.⁴ As symptom management is an essential component of palliative care, holistic care, which encompasses physical, psychosocial, and spiritual aspects, represents a rational approach for the relief of incurable symptoms at the end stage of life for terminal patients.⁵

The concept of symptom cluster has been introduced to examine the pathogenesis of terminal diseases and cited to support the practice of no longer adopting the pathophysiology of a single disease as the basis for treating a terminal disease. In addition to passive reduction of unnecessary medication and drug use, the concept of symptom cluster further highlights the importance of considering total suffering in treating terminal diseases.⁶

Palliative care embraced four principles promulgated by the World Health Organization’s National Cancer Control Programmes: Policies and Managerial Guidelines⁷ to manage total suffering in terms of symptom control. “Control” and “prevention” are underlined as the two principles of palliative care, followed by the spiritual well-being of the patients which relies on the patients’ own efforts as it is beyond the help of any external resources. The last principle emphasizes that, in treating incurable diseases, ensuring the best possible quality of life for terminal patients is more important than extending the quantity of life. Genuine patient-centered care should strive for the promotion of overall well-being and quality of life, reduce pointless medical treatment, and avoid prolonged suffering and pain for terminal patients with the ultimate aim of facilitating peaceful death.

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